DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96 — 18

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ 50,000.00
b. FFY 98 $ 50,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A(2b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Non-State-Owned Psychiatric Hospital Payment methods

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 45 CFR 204.1

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 27, 1996

16. RETURN TO:
Bridget Landers
State Plan Coordinator
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 30, 1996

18. DATE APPROVED:
May 4, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1996

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
ARA, DMSO, Boston Region

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

State Plan Under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

Methods Used to Determine Rates of Payment for Non-State-Owned Psychiatric Hospital Services

I. General Description of Payment Methodology

Non-acute hospitals participating in the Massachusetts Medical Assistance Program include Psychiatric Hospitals.

The basic payment methodology described in this attachment was effective October 1, 1985. Changes are proposed in response to the passage of M.G.L. c. 118 E, sec 13A and M.G.L. 118 G. Psychiatric hospitals are governed by 114.1 CMR 40.00 These provisions do not apply, however, to ICF/MRs having more than 15 beds, which are reimbursed under 114.1 CMR 29.00 or to non-state-owned chronic and rehabilitation hospitals which are governed by 114.1 CMR 39.00.

I.A. The following is a general description of the chief components of the payment method for non-state-owned psychiatric hospital services.

1. Hospital allowable costs, with the exception of the working capital component, are determined from a base year that has been fixed at FY 1984. These FY 1984 costs are restricted by the implementation of base-year cost screens that eliminate excessive costs. Expenses disallowed in the base year are never rolled into payment rates for subsequent years. The establishment of a fixed-base year, therefore, provides a strong incentive for cost efficiency. Rates of payment are adjusted to affect appropriate cost increases or decreases resulting from changes in volume, case-mix, inflation, and other factors. The working capital component is determined from the operating and capital requirements of the rate year.

2. Rates of payment have a direct relationship to the actual charges incurred by a patient based on the services utilized by that patient. Under this charge-based system hospitals are

able to charge more for patients who require more services. Thus, this system is responsive to hospital financial needs in the face of changing patient utilization of services.

3. A payment-on-account factor (PAF), essentially a ratio of allowed hospital costs to allowed hospital charges, is also calculated for each hospital. A single payment-on-account factor will apply to a hospital's inpatient and outpatient services; Medicaid reimbursement will be equal to charges (or daily charge) times the payment-on-account factor.

I.B. The following describes the changes made to implement applicable provisions of Chapter 270 of the Acts of 1988.

1. The Commonwealth will adjust rates of payment to compensate non-state-owned Psychiatric Hospitals for cost increases related to recruiting and retaining direct-care labor. Rates will be adjusted in two ways: 1) the inflation adjustment used to derive the budget-year operating costs will be increased to reflect the increased costs of direct care personnel in the Commonwealth; and 2) hospitals which can demonstrate extraordinary cost increases for direct care personnel, in excess of the amount allowed through inflation, will receive an adjustment as a cost beyond control.

II. Definitions

Adjusted Base Year Volume. The actual Base year volume adjusted to include the volume associated with recurring CBC's, new services and transfers on of cost and exclude volume associated with discontinued services and transfers off of cost.

Base Year. Base year shall mean the hospital's fiscal year 1984.

CBC. Cost beyond control

Charge. The amount to be billed or charged by a hospital for each specific service within a revenue center.

Department of Public Health. The Department of Public Health established under M.G.L. c. 17, s. 1.

DHCFP-450. DHCFP-450, Report of Charges and Volume, is a report which documents a hospital's charges and volume, utilized for the purpose of adjusting the cost-to-charge ratio or the payment on account factor should the facility increase their charges.

Discontinued Service. A health service, supply, or accommodation that conformed in scope to a cost center as defined in Chapter III of the Reporting Manual which:

- o is included in the adjusted base year cost and which will not be offered during the budget year, or
- o is being offered and terminated during the budget year.

DHCFP. The Division of Health Care Finance and Policy is established under M.G.L. c.118 G, formerly the Rate Setting Commission.

FTEs. FTE is an acronym for full-time equivalent staff. To compute full-time equivalents (FTEs), divide the total annual paid hours (including vacation, sick leave and overtime) for all employees in each cost center by a forty (40) hour work seek annualized to a norm of 2080 hours.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, or political subdivision of the Commonwealth.

Gross Patient Service Revenue (GPSR). Gross patient service revenue is the total dollar amount of a hospital's charges for services rendered during the reporting period, generally within a fiscal year.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual; promulgated by DHCFP under 114.1 CMR 4.00.

Intermediate Year. The hospital fiscal year just before the current rate year.

Inpatient Day. HURM standard unit of measure to report care of patients

admitted to a hospital including the day of admission, but not the day of discharge. If both occurs on the same day, the day is considered a day of admission and counts as one inpatient day.

Non-acute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 29.

PAF. Payment on Account Factor is a percentage applied to charges to calculate a purchaser's discounted reimbursement level.

Psychiatric Hospital. Any psychiatric facility licensed under M.G.L. c. 19, s.29.

Publicly Aided Individual. A person who received health care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

Rate Year. The rate year will be 10/1 to 9/30.

Reasonable Financial Requirements (RFR). The sum of the hospital's rate year operating requirements, rate year capital requirements, and rate year working capital requirements.

State-Owned Non-acute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility operated by the Department of Mental Health.

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

III. Medicaid Reimbursement Methodology for Non-State-Owned Psychiatric Hospitals

For any particular rate year, a provider-specific Medicaid payment-on-account factor (PAF) will be calculated. This PAF is, in turn, applied to charges billed to the Division of Medical Assistance by the hospital. The PAF is the ratio of the hospital's rate year allowable costs, called "RFR" to the rate-year charges, called "GPSR". The Medicaid PAF is computed as follows:

- o Data Sources: Submission, review, and acceptance of hospital cost information;
- o Determination of Operating Requirement;
- o Determination of Capital Requirement;
- o Determination of reasonable financial requirements (RFR) for the rate year;
- o Determination of approved gross patient revenue service (GPSR) for the rate year.

Each of these steps is explained in greater detail below.

III.A. Data Sources: Submission, Review and Acceptance of Hospital Cost Information.

Each non-state-owned Psychiatric Hospital must file with the DHCFP reports of its costs, revenues, statistics, charges, and other related information in accordance with time-frames and reporting mechanisms specified by the DHCFP. Exceptions to certain reporting requirements are allowed in specified circumstances.

Information reported by each hospital may be adjusted upon audit. If the specified data sources are unavailable or inadequate, payment rates will be determined using the best alternative data source and/or a statistical analysis will be performed to insure

comparability of data.

III.B. Determination of Operating Requirement

The Operating Requirement is the sum of the allowed base year operating costs, adjustments to base year operating costs, inflation, volume, costs beyond control and new services.

1. Allowed Base Year Operating Costs: The base-year for allowed operating costs shall be FY 1984. This includes only costs incurred or to be incurred in the provision of hospital care and services, supplies, and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual, the Massachusetts HURM (found at 114.1 CMR 4.00) and Generally Accepted Accounting Principles. A double stepdown cost allocation system shall be applied to these costs to determine full costs incurred by each hospital department. A double stepdown allows for full interdepartmental cost allocations between nonrevenue producing departments as well as revenue producing departments. The first stepdown distributes all direct and indirect costs of all departments to various cost centers according to a statistical basis of allocation. After the first stepdown is completed, the costs that have been allocated to the nonrevenue departments are then redistributed to the revenue-producing departments using the same statistical basis of allocation as in the first stepdown.

2. Adjustments to Allowed Base-Year Operating Costs: Base-year operating costs as reported by the hospital are subject to the following limitations: base-year cost screens, adjustments to variables, and base year cost adjustments.

   a. Base-Year Cost Screens Effective July 1, 1986, base-year costs found to be excessive will be eliminated from allowable base-year costs. For psychiatric hospitals, a single base year cost screen is applied to adjusted total

costs. The regression employed uses all psychiatric hospitals, with adjusted total cost as the dependent variable. Independent variables are: (1) Boston metropolitan location, (2) revenue/cost ratio, and (3) average length of stay.

b. Adjustments to Variables In the event that either audit results or information provided by a hospital change the variables used in the cost screens, the value of the affected cost caps for that hospital only will be recomputed. Any resulting changes to base-year allowable costs will be credited to the hospital at its next budget or charge modification review.

c. Base-Year Cost Adjustments Base-year costs may also be subject to adjustments stemming from audit results, from cost reductions resulting from discontinued services or the transfer off of costs, or to annualized base-year costs not in place during the full base year.

3. Inflation

a. For fiscal year 1997, the DHCFP will adjust allowed base year operating cost using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category is non-labor portion of the HCFA market basket for non-acute hospitals. The composite inflation adjustment for fiscal year 1997 is 2.05%. There will be no adjustment upward or downward of the components of the inflation adjustment to account for over-or under-projection.

b. The composite inflation index as calculated in accordance with the preceding paragraph is increased by .02 pursuant to M.G.L.c.118 G.

4. Volume:

Allowed base-year operating costs shall be further adjusted to reflect reasonable volume increases and decreases as follows:

a. The DHCFP shall require each hospital to report its costs, revenue, and volume data in accordance with the reporting requirements contained in 114.1 CMR 40.03. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the base year direct and indirect costs for that cost center divided by the year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost shall be part of the volume used in the computation of the volume allowance. Any allowance due to new services, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

b. For projected volume increases or decreases from the intermediate year to the rate year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.

c. For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.

d. An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the rate year shall be calculated as the product of the projected increase in units

multiplied by 50% of the allowed unit cost inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the base year to the rate year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost inflated by the base to rate year composite inflation index.

e. For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease Cost	Allowed Marginal
Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There shall be no downside corridors for volume decreases.

f. A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as describes above, multiplied by the Allowed Unit Cost inflated by the base to rate year composite inflation index.

5. Costs Beyond Hospital Control (CBCs)

A. Under specific circumstances, a non-state-owned Psychiatric Hospital may request an increase in its allowed base year operating costs to include cost increases due to CBCs. A CBC is an unusual and unforeseen increase in reasonable and allowable costs

which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in the hospital's operating requirement.

(1) A cost shall not be determined to be a CBC if in a prior fiscal year the DHCFP approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.

(2) The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the inflation and volume allowances.

(3) The timing and amount of the increase in costs must be reasonably certain. If the hospital does not begin to expend costs for which it has received a CBC adjustment within six months, the hospital must notify the DHCFP that approved amounts were not expended and the DHCFP will deduct such costs from RFR.

(4) A CBC shall be allowable only if the amount requested is greater than one-tenth of 1% of the hospital's total patient care costs.

(5) Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in (d) above.

(6) A CBC shall be allowable only if necessary for the appropriate provision of services to publicly aided individuals and if the costs cannot otherwise be met through efficient management and

economic operation.

B. The following are the qualifying incidents or circumstances for CBCs:

(1) Costs generated by correcting deficiency contingencies or recommendations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C.§§1395 et seq. and 42 U.S.C.§§ 1396 et seq. An example of this category is a cost incurred or expected to be incurred within six (6) months to comply with a change in the manual issued after 1984 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a CBC. Hospitals which have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be A CBC is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable CBC shall not be recognized. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the increased costs and verification that the increased costs are reasonable to meet the government requirement.

(2) Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by

an inflation factor, it shall not be allowed as a cost beyond reasonable hospital control. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

(3) Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.

(4) Allowed operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, §§25B - 25G. These costs must be segregated from other allowed operating costs. The hospital must demonstrate that the increased cost requests are reasonable. The hospital will not be permitted to make a volume adjustment for departments affected by a determination of need if the hospital requests that the operating cost associated with the determination of need be included as a CBC. Any volume allowance due to DoN shall be netted out if costs associated with it are submitted as a CBC.

(5) Wage parity adjustments resulting from mergers which are clearly demonstrated to be

cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the individual hospitals have projected, and in no event are spending more than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring cost beyond control and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rates.

(6) Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments.

(a) Documentation shall provide a projection of the costs savings to be achieved as a result of adjustments to wages and salaries.

(b) This adjustment will be considered a non-recurring cost beyond control. Costs associated with this CBC will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rate years.

(7) Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This CBC is not to exceed actual expenditures for such increases.

(a) Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for CBC allowance.

(b) The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force.

(c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.3.

(d) The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate will be determined by the DHCFP with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

(i) Outlier wage rates as defined by the DHCFP shall be excluded from the computation;

(ii) Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region;

(iii) If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight; and

(iv) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.

(v) The determined Medicare Labor Market Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk
	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnstable

Dukes
Nantucket
Rural Franklin

(e) In order to be eligible for this exception,a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the criteria established in St. 1988, Chapter 270. These criteria are:

(i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, Joint Commission on Accreditation of Health Care Organizations standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care;

(ii) persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels; and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels.

(8) A CBC is allowable for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from either the base year or the last year for which a casemix adjustment has been made (whichever was later) to the intermediate or rate year. The higher intensity level in the intermediate or rate